

# Rethinking Early Intervention for Chronic Pain

By Michael Ferguson

MINIMALLY INVASIVE SPINAL CORD STIMULATION PROVIDES HOPE FOR PATIENTS WITH DISABLING PAIN RESULTING FROM CHRONIC RADICULOPATHY OR FAILED BACK SURGERY SYNDROME.



Thomas P. Ragukonis, MD

**IN 2009, ST. JUDE** Medical, Inc. appointed Thomas P. Ragukonis, MD, Director of Bergen Pain Management and Clinical Assistant Professor of Anesthesiology at Rutgers New Jersey Medical School, to its Neuromodulation Strategic Physicians Counsel. One of 15 elite physicians from across the country on the counsel, Dr. Ragukonis uses his expertise in spinal cord stimulation to assess St. Jude Medical's products and analyze national trends in pain management.

"I implant spinal cord stimulators in 80 to 85 percent of the patients I bring to trial, which is well above the national average," says Dr. Ragukonis, who is board-certified in anesthesiology and pain medicine. "My experience using the

device to treat a number of conditions, including post-laminectomy syndrome, chronic radiculopathy or failed back surgery syndrome, has been magnificent. Spinal cord stimulation gives patients hope where before there was none."

## Personalized Care

Each patient experiences pain differently, so Dr. Ragukonis tailors intervention according to findings on initial exams, which include appropriate imaging scans and thorough histories.

Dr. Ragukonis collaborates with board-certified spine surgeons to offer the full spectrum of minimally invasive procedures, including nucleoplasty, radiofrequency neurolysis, endoscopic discectomy and endoscopic percutaneous lumbar fusion. When patients — particularly elderly, debilitated patients — present with chronic back pain that isn't sufficiently addressed nonsurgically, spinal cord stimulation may be the most beneficial treatment option.

## Intercepting Pain

Traditional spinal cord stimulator implantation requires surgeons to perform a laminectomy — removing a piece of the vertebra — for access to the spinal cord. Dr. Ragukonis' minimally invasive approach eliminates the need for laminectomy.

Treatment begins with a trial period. Dr. Ragukonis places the needle into the epidural space under fluoroscopic guidance. Instead of connecting the leads that transmit the pain-disrupting signal to the spinal cord to a generator,

he keeps them on the body's surface, covered by a bandage. Patients recover and go home the same day.

"Patients leave the office with a device no more difficult to control than a television remote," Dr. Ragukonis says. "They receive programs that adjust the severity of the pain sensation and allow them to relocate the source of the stimulation. They test-drive the device externally for three or four days and return to the office. If they report that it helped reduce their pain by at least 50 percent, I recommend implantation."

Patients return to the office three to four weeks after the test-drive period for full implantation. Like a cardiac pacemaker, the device is subcutaneous. Dr. Ragukonis places the generator in the flank and connects it to the already-implanted leads.

Patients periodically return so Dr. Ragukonis can fine-tune the device.

## Earlier Intervention

Dr. Ragukonis advocates early intervention, as spinal cord stimulation offers a minimally invasive alternative to open surgery or ineffective injections.

"Spinal cord stimulation should be considered much earlier than it is," Dr. Ragukonis says. "Waiting for four or five years for pain relief is ludicrous, especially when there's an effective treatment available. This isn't a radical intervention — especially when performed in a minimally invasive manner."

For more information about Bergen Pain Management, visit [bergenpain.com](http://bergenpain.com). ■